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## ABSTRACT

The delivery of services in a health maintenance organization (HMO) provides many opportunities for innovation. There is a growing awareness that many outpatient medical visits are related to psychological or social needs. Because of the economic incentive for HMO's to reduce inappropriate utilization, psychologists and psychotherapists will play a more influential role in health care delivery in the near future. Contributions can be made on all levels of prevention. For example, primary prevention could include community health education programs. Secondary prevention could bring together patients who are dealing with various life experiences and provide them with early interventions. Tertiary prevention could help patients to readjust by providing social support and by helping prevent relapses. (JAC)

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THERAPISTS' CONTRIBUTIONS TO PROGRAM DEVELOPMENT IN AN HMO

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# Therapists Contributions to Program Development in an HMO<sup>1</sup>

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The delivery of service in a health maintenance organization provides many opportunities for innovation. At the present time psychologists may not be in a position to contribute to the development and implementation of new programs, but this situation may change over the next decade. There is a growing awareness that the majority of outpatient medical visits are related to psychological or social needs rather than to purely biological processes. Because of the economic incentive for HMO's to reduce inappropriate utilization, we might predict that psychologists will be playing a more influential role in health care delivery in the near future. The question I would like to address is how psychotherapists can contribute to this process.

First, we need to deal with a basic problem of how psychotherapists are conditioned to think of themselves professionally. Graduate training for most psychologists sharply distinguishes between clinical work (which is usually seen as an "art") and research or program development (which is seen as more rigorous). Most psychologists who choose to become therapists end up feeling that they are not qualified, or at least not welcome, in the academy of thinkers who are making "contributions to knowledge." Any definition of psychological research which excludes the clinician creates an artificial science which is unlikely to have a meaningful impact on many of the problems our patients are facing. An alternative view of research comes from anthropology, and provides a model which is more likely to help us develop appropriate responses to the needs of the people we serve. In this model, the clinicians'

experiences in listening to the needs of his or her patients and participating in their change process can be utilized as a survey or needs assessment which forms the basis for new programs to meet these needs more effectively. This type of clinical data-gathering, which many of our graduate school teachers might call useless because it does not follow any experimental principles, can be very valuable if used appropriately. It is a type of participation-observation which has been used extensively by anthropologists, and more recently by community psychologists seeking to understand various community systems. The purpose of this kind of research is not to prove or disprove, but to discover. Reichenbach (1958) contrasted this type of research, conducted in what he termed "the context of discovery", from experimental research conducted in the "context of justification". He emphasized that new discoveries often derive from educated guesses made by people with extensive experience, Often the researcher

cannot name a method by means of which he found the theory, and can only say that it appeared plausible to him, that he had the right hunch, or that he saw intuitively which assumption would fit the facts, (p. 230)

This is a legitimate model for research, and clinicians need to encourage each other to use it to generate a greater understanding of the needs of the populations we are serving.

#### Clinical Examples

I would like to discuss the process of inquiry which clinicians can go through, and illustrate how the process can be used to influence program development. There are several questions which we need to ask ourselves about our practice. The first is "What are the common problems my patients are reporting?" These problems might be different in various settings. Crisis intervention therapists have written extensively about problems commonly reported to them,

and have developed approaches to these "generic" crisis which provide for the most economical, as well as the most effective, interventions. Slaikau's (1983) book reports several examples. Psychotherapists in medical settings need to engage in a similar process, which might result in greater understandings of the personal change process for patients with hypertension, chronic pain, or even simply patients who overutilize medical services with no specific diagnostic problem. A real advantage for HMO psychologists is that they have ongoing contact with physicians and other health care professionals who can give us a much broader-based appreciation of the problems which patients have, and how some people adjust to them. Psychotherapists in independent practice do not have opportunities to find out about patients with particular diseases who do not have major difficulties in coping. By working on a team with physicians we can get a well rounded picture of how the adjustment process works. We can then use this information to help patients having difficulties. Daily contact with physicians involved in all aspects of medical practice enhances this process. My guess is that this happens in medical schools also, but in HMO's the patients are shared to a much greater extent than in other settings, and the opportunities for "cross pollination" is greatly expanded.

A second question is "Are there similarities in the processes which patients are going through to solve these problems"? What seems critical? In medical settings the endorsement of therapy by the patient's primary care physician is often helpful. Other aspects of the change process might involve utilization of new information, establishment of social support, and changes in self-esteem. Setting-up contact with patients who are successfully coping might be very helpful to our patients. This is quite easy to do in an HMO.

A third question is "Can any aspects of this process be handled more

economically, e.g., by educational classes or groups?" For example, many patients referred to therapy for help in dealing with stress might benefit from a series of small-group discussions and exercises on stress reduction prior to or in conjunction with the initiation of therapy. For some patients the groups themselves might be sufficient without additional therapy. In an HMO, psychotherapists can work closely with health educators who can play an important role in the intervention process for many patients. We have set up programs of this type at our Medical Center.<sup>2</sup>

#### Prevention Programs

Our observations are also relevant to prevention, and I believe that therapists can contribute to all three levels of prevention: primary, secondary and tertiary.

Primary Prevention. Although healthcare delivery systems are typically not involved in primary prevention, thinking about how problems can be prevented is often very useful for the development of programs. Community psychologists have developed primary prevention programs for school systems and other institutions, and as HMO membership grows, administrators may come to see a payoff for programs in school systems or police departments as a way of early intervention for persons who would otherwise end up costing more money to the healthcare system. Health education programs sponsored by HMO's are examples to the types of services that could be developed. Classes on difficulties of parenting or on dangers of smoking or alcohol are primary prevention efforts that could be expanded in the future. Therapists can provide input to health educators based on experiences with patients which suggest what types of information and/or training are most likely to have an impact on patients behaviors. Attacking obesity and smoking in elementary schools might have a real payoff to an HMO in an area where a significant proportion of the population are members.

Secondary Prevention. This is the area where I see the most promise for therapists to contribute. The question for secondary prevention is -- what might be done to reduce the severity of the problem, and how can we intervene earlier? Developmental and clinical psychologists have done a great deal of the basic research in this area, and have provided us with lists of "high risk situations." Life experiences like deaths in the family, divorce, loss of job, etc. are well known producers of stress that lead to increases in both medical and emotional difficulties. Therapists with experiences treating patients who are dealing with these difficulties can see similarities among patients that can contribute to programatic interventions, such as Kelly and Wallerstein (1980) have done for children whose parents are going through a divorce. Programs of this type do not eliminate the need for individual or family therapy, but supplement these more traditional approaches by providing interventions that are available earlier, and in a less threatening way than a referral for therapy. In a medical setting, many opportunities are available for early intervention aimed toward secondary prevention. Events like abortions, diagnosis of chronic illness, heart attacks, strokes, etc. all have dramatic impact both on individuals involved and their families. Programs can be developed for each type of experience which could help those involved work through them as well as possible, and as soon as possible. Physician involvement in these programs makes early referral much more likely.

Tertiary Prevention. This is the area where therapists are most familiar. The prevention question here is -- what can reduce the probability of recurrence of this problem and maximize the patient's potential for readjusting following the event. We all know patients who have gone through traumatic experiences and managed to put their lives back together, while others going through lesser trauma never seem to recover adequately. Researchers have spent considerable

time, money, and energy trying to determine what makes the difference, and the results seem to point to variables such as ego strength prior to the experience and social support in the months and years following. While healthcare delivery systems can do little for ego strength, we can do a great deal in the area of social support. Psychotherapists can provide administrators with available research, as well as clinical experiences, that point out the cost-effectiveness of social support--especially for patients who are high utilizers of the medical system. At our medical center, we now have various types of ongoing support groups, and our experience is that these do not drain the system. Usually patients stay in the groups for several months and then become involved in self-help groups in the community. They may have needed the medical system to endorse the idea of a support group, but once they're in it, they are more than likely to reach out to other resources. If we think about our caseloads, we can probably come up with many more types of support groups that could be formed. Once again I want to emphasize that physicians can provide us with patients who seem to be adapting to their illnesses successfully and these patients can be very helpful in the support groups we develop.

A specific example of tertiary prevention that has benefitted from clinical experience is the area of relapse prevention. Alan Marlatt (1980) has examined relapse histories of patients who have returned to alcohol, drugs, smoking, overeating, and gambling after periods of abstinence. He found very similar patterns: There were various high risk situations that led each group to return to their old habit. Marlatt developed strategies to teach patients so that they could be prepared for the high risk situations they were bound to encounter. He found out what worked for patients, and taught it to other patients. Clearly the impetus for the program came from clinical observations.

I would like to conclude by restating a point that has been made throughout this symposium. An HMO setting can be an ideal place for creative clinical work, because the opportunities for interdisciplinary collaboration exist to a greater extent than in many other settings and the collaborations are valued because they can lead to more effective treatment for patients that are very costly to the system, both in terms of money and morale. With this incentive, the HMO system may be willing to explore newer approaches to the delivery of healthcare in which psychological and social components of illness are given their due recognition. Clinicians have a great deal to contribute to this process, because it is in the clinical interaction that we have the clearest opportunity to discover what the patient needs, and how the provider, and the healthcare system, can best respond.

#### REFERENCES

Kelly, J., and Wallerstein, J. Surviving the breakup: How children and parents cope with divorce. New York: Basic Books, 1980.

Marlatt, G.A., & Gordon, J.R. Determinants of relapse: Implications for the maintenance of behavior change. In P.O. Davidson and S.M. Davidson (Eds.), Behavioral Medicine: Changing Lifestyles. New York: Brunner/Mazel, 1980.

Reichenbach, H. Rise of scientific philosophy. Berkeley: University of California Press, 1958.

Slaikew, K. Crisis intervention: A hand-book for practice and research. New York: Allyn & Bacon, 1983 in press.

#### Footnotes

1. Paper presented at symposium on "Compromises and challenges for therapists in Health Maintenance Organizations" at the Convention of the American Psychological Association, Washington, D.C., August, 1982.
2. A summary of the program in the Psychiatry Department is available from Jane Brooks, Ph.D., and the program in the Health Education Department is available from Lorinda Sheets, M.P.H. Both are at the Kaiser-Permanente Medical Center, 27400 Hesperian Blvd., Hayward, California 94545.